

Facility Name & ID Number GOOD SAMARITAN SOCIETY - MT CARROLL

0007344 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	72	Skilled (SNF)	72	26,280	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	72	TOTALS	72	26,280	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				
		3 Medicaid Recipient	4 Private Pay	5 Other	6 Total	
8	SNF	13,308	10,250	1,630	25,188	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	13,308	10,250	1,630	25,188	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.84%

D. How many bed-hold days during this year were paid by the Department? _____ (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

MEALS ON WHEELS

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
 YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
 YES NO

I. On what date did you start providing long term care at this location?
 Date started 01/01/1970

J. Was the facility purchased or leased after January 1, 1978?
 YES Date _____ NO

K. Was the facility certified for Medicare during the reporting year?
 YES NO If YES, enter number of beds certified 72 and days of care provided _____

Medicare Intermediary NORIDIAN

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES NO

Tax Year: 01/01/09 Fiscal Year: 12/31/09

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number **GOOD SAMARITAN SOCIETY - MT CARI** # **0007344** Report Period Beginning: **01/01/2009** Ending: **12/31/2009**

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	191,654	11,468	5,323	208,445		208,445	(293)	208,152		1
2	Food Purchase		150,000		150,000		150,000	(12,281)	137,719		2
3	Housekeeping	77,919	16,927		94,846		94,846	(450)	94,396		3
4	Laundry	50,300	9,676		59,976		59,976	(261)	59,715		4
5	Heat and Other Utilities			87,930	87,930		87,930		87,930		5
6	Maintenance	58,206	12,637	56,257	127,100		127,100	(1,076)	126,024		6
7	Other (specify):*			7,512	7,512		7,512		7,512		7
8	TOTAL General Services	378,079	200,708	157,022	735,809		735,809	(14,361)	721,448		8
	B. Health Care and Programs										
9	Medical Director	1,304,017	136,143	3,163	1,443,323		1,443,323		1,443,323		9
10	Nursing and Medical Records		35	144,379	144,414		144,414	(59,232)	85,182		10
10a	Therapy	82,507	1,855	12,029	96,391		96,391	(23,614)	72,777		10a
11	Activities	30,922	33	2,410	33,365		33,365	(767)	32,598		11
12	Social Services							(1)	(1)		12
13	CNA Training										13
14	Program Transportation			2,835	2,835		2,835		2,835		14
15	Other (specify):*	47,561			47,561		47,561		47,561		15
16	TOTAL Health Care and Programs	1,465,007	138,066	164,816	1,767,889		1,767,889	(83,614)	1,684,275		16
	C. General Administration										
17	Administrative	69,601		150,815	220,416		220,416	50,117	270,533		17
18	Directors Fees										18
19	Professional Services			3,133	3,133		3,133		3,133		19
20	Dues, Fees, Subscriptions & Promotions			13,245	13,245		13,245	(12,761)	484		20
21	Clerical & General Office Expenses	90,542	16,150	44,915	151,607		151,607	(2,385)	149,222		21
22	Employee Benefits & Payroll Taxes			474,465	474,465		474,465	(11,049)	463,416		22
23	Inservice Training & Education			9,820	9,820		9,820	(20)	9,800		23
24	Travel and Seminar			1,444	1,444		1,444	(552)	892		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			17,004	17,004		17,004	10,704	27,708		26
27	Other (specify):*	12,387			12,387		12,387	(12,387)			27
28	TOTAL General Administration	172,530	16,150	714,841	903,521		903,521	21,667	925,188		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,015,616	354,924	1,036,679	3,407,219		3,407,219	(76,308)	3,330,911		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			191,690	191,690		191,690		191,690			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			4,541	4,541		4,541		4,541			35
36	Other (specify):*											36
37	TOTAL Ownership			196,231	196,231		196,231		196,231			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			39,992	39,992		39,992		39,992			42
43	Other (specify):*			6,529	6,529		6,529	(6,528)	1			43
44	TOTAL Special Cost Centers			46,521	46,521		46,521	(6,528)	39,993			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,015,616	354,924	1,279,431	3,649,971		3,649,971	(82,836)	3,567,135			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(12,281)	2		4
5	Telephone, TV & Radio in Resident Rooms		11		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds	3,178	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(124,514)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (133,617)		\$	30

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule	50,781		35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 50,781		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (82,836)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4
		Yes	No	Amount	Reference
38	Medically Necessary Transport.			\$	38
39					39
40	Gift and Coffee Shops				40
41	Barber and Beauty Shops				41
42	Laboratory and Radiology				42
43	Prescription Drugs				43
44					44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	TOTAL (C): (sum of lines 38-46)			\$	47

BHF USE ONLY							
48		49		50		51	52

GOOD SAMARITAN SOCIETY - MT CARROLLID# 0007344Report Period Beginning: 01/01/2009Ending: 12/31/2009

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Uniform/resours dev	\$ (4,106)	21	1
2	Administration	(288)	21	2
3	Meals		2	3
4	Employee Meals		2	4
5	deferred maintenance expense	1,141	6	5
6	O/P Med Suply Pvt	(3)	10	6
7	O/P Nursing Sply PVT	(256)	10	7
8	Employee Garnishment	(60)	21	8
9	Postage	(77)	21	9
10	Transportation	(2,059)	6	10
11	Int Inc Past Due Accounts	(70)	21	11
12	Employee Relations Inc	(153)	21	12
13	Cable TV	(717)	11	13
14	Public Rel Reimb	(491)	20	14
15	Dues Non reimb	(75)	20	15
16	Bank Charges	(14)	21	16
17	Prescr Drugs Reimb	(55,125)	10	17
18	Inoculations	(1,126)	10	18
19	Supplies Marketing	(472)	21	19
20	Travel Reim Marketing	(20)	24	20
21	Adv/Promo Marketing	(98)	20	21
22	Adv/Newspaper	(4,100)	20	22
23	Adv/ Newsletter	(2,362)	20	23
24	Inter Center Reimburse	(1,774)	20	24
25	Adv/Radio	(1,622)	20	25
26	Adv/ Yellow Pages	(1,963)	20	26
27	Adv/ Phone	(120)	20	27
28	Adv Signage	(156)	20	28
29	Salaries Res Dev	(12,393)	27	29
30	Vacation Acc- Res Dev	6	27	30
31	FICA Res Dev	-948	22	31
32	Supplies Res Dev	-176	21	32
33	Staff Dev Res Dev	-20	23	33
34	Purch Serv Radiology MDCRE	-3101	43	34
35	Therapy Offset	-23610	10a	35
36	Purch Serv Lab MDCRE	-3427	43	36
37	Med Supplies	-908	10	37
38	Out of State Travel	-532	24	38
39	Admin supplies	-147	21	39
40	Nursing Supplies	-1814	10	40
41	Therapy Supplies	-4	10a	41
42	Activities Supplies	-50	11	42
43	Social Service Supplies	-1	12	43
44	Laundry Supplies	-261	4	44
45	House Keeping Supplies	-450	3	45
46	Dietary Supplies	-293	1	46
47	Plant Supplies	-158	6	47
48	Unemployment Resourse Dev	-61	22	48
49	Total	(124,514)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number GOOD SAMARITAN SOCIETY - MT CARROLL# 0007344

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	(293)	0	0	0	0	0	0	0	0	0	0	(293)	1
2	Food Purchase	(12,281)	0	0	0	0	0	0	0	0	0	0	(12,281)	2
3	Housekeeping	(450)	0	0	0	0	0	0	0	0	0	0	(450)	3
4	Laundry	(261)	0	0	0	0	0	0	0	0	0	0	(261)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(1,076)	0	0	0	0	0	0	0	0	0	0	(1,076)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(14,361)	0	0	0	0	0	0	0	0	0	0	(14,361)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(59,232)	0	0	0	0	0	0	0	0	0	0	(59,232)	10
10a	Therapy	(23,614)	0	0	0	0	0	0	0	0	0	0	(23,614)	10a
11	Activities	(767)	0	0	0	0	0	0	0	0	0	0	(767)	11
12	Social Services	(1)	0	0	0	0	0	0	0	0	0	0	(1)	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(83,614)	0	0	0	0	0	0	0	0	0	0	(83,614)	16
	C. General Administration													
17	Administrative	0	50,117	0	0	0	0	0	0	0	0	0	50,117	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(12,761)	0	0	0	0	0	0	0	0	0	0	(12,761)	20
21	Clerical & General Office Expenses	(2,385)	0	0	0	0	0	0	0	0	0	0	(2,385)	21
22	Employee Benefits & Payroll Taxes	(1,009)	(10,040)	0	0	0	0	0	0	0	0	0	(11,049)	22
23	Inservice Training & Education	(20)	0	0	0	0	0	0	0	0	0	0	(20)	23
24	Travel and Seminar	(552)	0	0	0	0	0	0	0	0	0	0	(552)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	10,704	0	0	0	0	0	0	0	0	0	10,704	26
27	Other (specify):*	(12,387)	0	0	0	0	0	0	0	0	0	0	(12,387)	27
28	TOTAL General Administration	(29,114)	50,781	0	21,667	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(127,089)	50,781	0	(76,308)	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number GOOD SAMARITAN SOCIETY - MT CARROLL# 0007344

Report Period Beginning:

01/01/2009 Ending:

12/31/2009

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	0	0	0	0	0	0	0	0	0	0	0	0	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(6,528)	0	0	0	0	0	0	0	0	0	0	(6,528)	43
44	TOTAL Special Cost Centers	(6,528)	0	0	0	0	0	0	0	0	0	0	(6,528)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(133,617)	50,781	0	(82,836)	45								

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Good Samartain Society	100					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	17 Admin/Acting	\$ 150,815	The Evangelical Lutheran Good Samaritan Society	100.00%	\$ 200,932	\$ 50,117	1
2	V	22 Workers Comp	69,341			77,306	7,965	2
3	V	22 Unemployment	5,578			5,837	259	3
4	V	26 Insurance	17,003			27,707	10,704	4
5	V	22 Group Health Insurance	205,908			187,644	(18,264)	5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 448,645			\$ 499,426	\$ * 50,781	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number GOOD SAMARITAN SOCIETY - MT CAR # 0007344 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number GOOD SAMARITAN SOCIETY - MT CARROLL # 0007344 Report Period Beginning: 01/01/2009 Ending: 2/31/2009

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number

GOOD SAMARITAN SOCIETY - MT CARE

0007344

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1	2	3	4	5	6	7	8	9	10										
										Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
										YES	NO				Original	Balance			
A. Directly Facility Related																			
Long-Term																			
1										1									
2										2									
3										3									
4										4									
5										5									
Working Capital																			
6										6									
7										7									
8										8									
9	TOTAL Facility Related					\$	\$		\$	9									
B. Non-Facility Related*																			
10										10									
11										11									
12										12									
13										13									
14	TOTAL Non-Facility Related					\$	\$		\$	14									
15	TOTALS (line 9+line14)					\$	\$		\$	15									

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 26,795 B. General Construction Type: Exterior Frame Number of Stories

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
 If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1			1968	\$ 5,720	1
2					2
3	TOTALS			\$ 5,720	3

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4		1970	1970	\$ 418,766	\$ 10,470	40	\$ 10,470	\$	\$ 417,894
5		1991	1991	912,127	34,430	20	34,430		863,907
6									
7									
8									
Improvement Type**									
9		1971		382	9	40	9		367
10		1976		3,352					3,352
11		1979		5,570					5,570
12		1980		1,419					1,419
13		1981		33,937					33,627
14		1982		29,188					29,188
15		1983		8,193					8,193
16		1984		1,224					1,224
17		1985		14,501					14,500
18		1986		11,402					11,402
19		1987		15,280					15,273
20		1988		14,406		20			14,405
21		1989		5,233	75	20	75		5,233
22		1990		24,930	26	20	26		24,917
23		1992		600					600
24		1993		2,434					2,434
25		1994		48,104	892	20	892		45,537
26		1995		36,887	137	15	137		36,875
27									
28									
29									
30									
31									
32									
33									
34									
35									
36									

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number GOOD SAMARITAN SOCIETY - MT CARROLL

0007344

Report Period Beginning:

01/01/2009 Ending: 12/31/2009

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Compressor Control Board	1996	\$ 2,027	\$ 135	15	\$ 135	\$	\$ 1,892	37
38	Air Conditioning	1996	98,766	6,584	15	6,584		92,182	38
39	Windows	1996	10,350	517	20	517		9,315	39
40	Return Air Duct	1996	1,030	52	20	52		700	40
41	Roof	1996	75,405	3,770	20	3,770		50,270	41
42	Instalation of Annumciator PA	1997	7,151					7,151	42
43	Instalation of New Ambulance	1997	1,924	128	15	128		1,550	43
44	Replace Roof	1997	11,921	596	20	596		7,202	44
45	Handrails	1998	5,049	337	15	337		3,983	45
46	Electric Emergency Panel	1998	4,300	215	20	215		2,580	46
47	Wiring for Network	1998	6,096	305	20	305		3,429	47
48	Repair Roof	1998	1,325		10			1,325	48
49	Steel Door	1999	2,284	152	15	152		1,662	49
50	Alarm System	1999	20,000	1,167	10	1,167		20,000	50
51	Alarm System	1999	8,080	404	20	404		4,074	51
52	Electric Maint Storage Building	2000	2,100	105	20	105		1,050	52
53	Maintenance storage building	2000	20,196	505	40	505		5,049	53
54	Water Heater	2000	3,500	350	10	350		3,412	54
55	Water Heater	2000	1,639	164	10	164		1,612	55
56	Piping and Wiring Dishwasher	2000	2,180	218	10	218		2,090	56
57	Painting for Kitchen	2000	2,126					2,126	57
58	Building Interior Renovations	2000	2,800	112	25	112		1,073	58
59	Paint inteior Renovations	2000	637					637	59
60	Wallpaper interior Renovations	2000	15,389					15,389	60
61	Extentions of Firewall	2000	3,985	199	20	199		1,843	61
62	Carpet Interior Renovations	2000	26,529					26,529	62
63	Oak Doors	2002	3,545	236	15	236		1,831	63
64	Wiring for Call Lights	2002	663	66	10	66		475	64
65	Vertical Blinds	2002	510		5			510	65
66	Restroom Remodeling	2002	385	39	10	39		276	66
67	Window Replacement Resident RM	2002	28,542	1,903	15	1,903		13,637	67
68	Tile	2002	536	54	10	54		380	68
69	Commercial Door	2002	509	34	15	34		243	69
70	TOTAL (lines 4 thru 69)		\$ 1,959,414	\$ 64,386		\$ 64,386	\$	\$ 1,821,394	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number GOOD SAMARITAN SOCIETY - MT CARROLL

0007344

Report Period Beginning:

01/01/2009 Ending: 12/31/2009

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 1,959,414	\$ 64,386		\$ 64,386	\$	\$ 1,821,394	1
2	Open Front Toilet Seat	2002	568	28	20	28		204	2
3	Water Heater	2002	3,840	384	10	384		2,688	3
4	Heater Covers	2002	9,000	900	10	900		6,525	4
5	Wing Shower Room Tile	2003	599	60	10	60		389	5
6	Boiler System replacement	2003	49,162	2,458	20	2,458		15,773	6
7	Counter top	2003	1,508	75	20	75		484	7
8	Tile for 300 Wing Shower Room	2003	537	54	10	54		349	8
9	Locks	2003	399	40	10	40		256	9
10	Outside Door for Kitchen	2003	1,326	88	15	88		538	10
11	Smoke Detectors	2003	1,650	165	10	165		908	11
12	Cabinets for Activity	2004	4,368	218	20	218		1,110	12
13	Window	2005	643	43	15	43		204	13
14	Exterior Door	2005	2,611	174	15	174		798	14
15	Heat/AC Unit	2005	2,975	298	10	298		1,262	15
16	AC Unit	2005	811	81	10	81		338	16
17	Blinds Resident Room Remodel	2005	656	131	5	131		536	17
18	Building Resident Room Remodel	2005	75,208	3,008	25	3,008		12,284	18
19	Drapes Resident Room Remodel	2005	8,199	1,640	5	1,640		6,695	19
20	Wallpaper Resident Room Remodel	2005	17,523	3,505	5	3,505		14,311	20
21	Wood Blinds	2006	636	64	10	64		249	21
22	Fire Sprinkler System	2006	140,294	5,612	25	5,612		21,512	22
23	Emergency Generator	2006	209,100	10,465	20	10,465		38,176	23
24	Fire Caulk	2006	2,650	265	10	265		949	24
25	Wall and Door Protectors	2006	6,729	673	10	673		2,187	25
26	Heat Pump	2006	685	69	10	69		211	26
27	Building Addition/Remodel	2006	18,692	748	25	748		2,555	27
28	Emergency Generator	2006	5,925	494	12	494		1,687	28
29	Salaries/Benefits	2006	573	23	25	23		78	29
30	Flooring for 5 Resident Rooms	2007	8,700	1,740	5	1,740		4,640	30
31	Double Door West Wing	2007	8,230	549	15	549		1,463	31
32	Repair Chiller	2007	5,220	522	10	522		1,262	32
33		2007	5,340	537	10	537		1,222	33
34	TOTAL (lines 1 thru 33)		\$ 2,553,771	\$ 99,497		\$ 99,497	\$	\$ 1,963,237	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 2,553,771	\$ 99,497		\$ 99,497	\$	\$ 1,963,237	1
2	Windows for Laundry Room	2007	1,586	106	15	106		211	2
3	Repair Chiller	2007	3,998	399	10	399		966	3
4	Hardware for Doors	2008	2,083	139	15	139		255	4
5	Blinds	2008	3,895	779	5	779		1,363	5
6	Chiller	2008	43,782	2,918	15	2,918		4,621	6
7	Rooftop AC Unit Replaced	2008	7,943	530	15	530		883	7
8	Adjustable Door Closer	2008	2,066	207	10	207		293	8
9	Doors	2008	3,720	247	15	247		413	9
10	Door and Frame	2008	4,990	333	15	333		444	10
11	ADA Gooseneck Faucet	2008	647	32	20	32		35	11
12	8x34 Kickplates for Doors	2008	630	84	7	84		126	12
13	Rooftop A/C Front Office Area	2009	15,714	611	15	611		611	13
14	Chicago Two Handle Faucet	2009	514	11	20	11		11	14
15	Backflow Preventor	2009	4,000	33	20	33		33	15
16	Asbestos Flooring Removal	2009	20,700	863	10	863		863	16
17	Laminate Wood Door/Amber Cherry	2009	729						17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,670,768	\$ 106,789		\$ 106,789	\$	\$ 1,974,365	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number GOOD SAMARITAN SOCIETY - MT CARROLL

0007344

Report Period Beginning:

01/01/2009 Ending: 12/31/2009

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 2,670,768	\$ 106,789		\$ 106,789	\$	\$ 1,974,365	1
2	Landscaping Seed Sod	1970	1,703					1,703	2
3	Sidwalks	1970	2,000					2,000	3
4	Cement Labor John Flynn	1975	1,986					1,986	4
5	Trees Memorial B Carpenter	1977	185					185	5
6	Misc	1979	466					466	6
7	Landscaping	1980	140					140	7
8	Plant Corner WindBreak Porch	1986	3,061					3,061	8
9	Excavation for Parking Lot	1988	3,474					3,474	9
10	Landscaping Plants	1989	1,419					1,418	10
11	Landscape	1991	10,002					9,780	11
12	Parking	1991	6,500					6,500	12
13	Parking Lot	1991	81,652					81,652	13
14	Sealing of Expansion Joints	1993	2,560					2,560	14
15	Teltra Pond Liner	1994	350					350	15
16	Gss Sign w/Logo	1994	8,841					8,841	16
17	Fencing	1994	2,716	151	15	151		2,716	17
18	Sidwalk west of building	1994	8,601	478	15	478		8,601	18
19	Seal cost Driveways and Parking	1997	3,050	153	20	153		1,906	19
20	Paving additional Parking	1999	6,640	332	20	332		3,431	20
21	Lumber for Raising Garden	2000	330	33	10	33		317	21
22	Garden Bed	2000	1,650	110	15	110		1,045	22
23	Shrubs	2000	677	68	10	68		637	23
24	Driveway repair	2000	4,455	446	10	446		4,158	24
25	Landscaping	2000	392	26	15	26		244	25
26	Repair Sidewalk	2002	4,270	427	10	427		3,167	26
27	Gazebo	2003	4,006	200	20	200		1,352	27
28	Fencing	2003	732	73	10	73		482	28
29	Stripping Repair Parking Lot	2004	5,865	586	5	586		5,865	29
30	Concrete Work	2004	3,335	222	15	222		1,186	30
31	Shed	2005	398	40	10	40		192	31
32	Logo Sign	2008	9,000	900	10	900		1,575	32
33	Concrete Parking Lot/Curb/Gutter	2008	77,206	5,153	15	5,153		7,209	33
34	TOTAL (lines 1 thru 33)		\$ 2,928,430	\$ 116,187		\$ 116,187	\$	\$ 2,142,564	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 2,928,430	\$ 116,187		\$ 116,187	\$	\$ 2,142,564	1
2	2009	1,975	91	20	91		91	2
3	2009	77,080	1,606	20	1,606		1,606	3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34		\$ 3,007,485	\$ 117,884		\$ 117,884	\$	\$ 2,144,261	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 656,437	\$ 64,552	\$ 64,552	\$		\$ 369,721	71
72	Current Year Purchases	43,268	3,236	3,236			3,311	72
73	Fully Depreciated Assets	394,233	2,380	2,380			394,233	73
74	Prior Yr Depreciation		478	478				74
75	TOTALS	\$ 1,093,938	\$ 70,646	\$ 70,646	\$		\$ 767,265	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Resident Use	Bus	2002	\$ 42,763	\$	\$	\$	6	\$ 42,763	76
77	Resident Use	1994 4X4 Truck	2004	3,500				4	3,500	77
78	Resident Use	2002 Osmobile Silhouette	2005	15,173	3,161	3,161		4	15,173	78
79	Resident Use	2005 Chev Pickup Trk	2009	14,273				4		79
80	TOTALS			\$ 75,709	\$ 3,161	\$ 3,161	\$		\$ 61,436	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 4,182,852	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 191,691	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 191,691	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,972,962	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	CIP	\$ 160,135	92
93			93
94			94
95		\$ 160,135	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$ _____			3
4	Additions							4
5								5
6								6
7	TOTAL				\$ _____			7

8. List separately any amortization of lease expense included on page 4, line 34. _____

This amount was calculated by dividing the total amount to be amortized _____
by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? _____

16. Rental Amount for movable equipment: \$ 4,541 Description: GSS Computers, Admin Technicare Nursing

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$ _____	\$ _____	17
18					18
19					19
20					20
21	TOTAL		\$ _____	\$ _____	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. _____ /2010 \$ _____

13. _____ /2011 \$ _____

14. _____ /2012 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	Ln 10a, col 3	hrs	\$	3,588	\$ 57,157	\$	3,588	\$ 57,157	1
2	Licensed Speech and Language Development Therapist	Ln 10a, col 3	hrs		85	4,273		85	4,273	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	Ln 10a, col 3	hrs		5,941	82,948		5,941	82,948	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$	9,614	\$ 144,378	\$	9,614	\$ 144,378	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number **GOOD SAMARITAN SOCIETY - MT CARROLL**# **0007344**Report Period Beginning: **01/01/2009**Ending: **12/31/2009****XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **12/31/2009**

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 145,102	\$	1
2	Cash-Patient Deposits	4,159		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	302,538		3
4	Supply Inventory (priced at)	14,163		4
5	Short-Term Investments	1,458,024		5
6	Prepaid Insurance	2,835		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(32,070)		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,894,751	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	5,720		13
14	Buildings, at Historical Cost	2,670,769		14
15	Leasehold Improvements, at Historical Cost	336,718		15
16	Equipment, at Historical Cost	1,169,648		16
17	Accumulated Depreciation (book methods)	(2,972,961)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	101,897		21
22	Other Long-Term Assets (specify):	4,692		22
23	Other(specify): CIP	160,135		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,476,618	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,371,369	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 42,461	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	4,159		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	252,244		30
31	Accrued Taxes Payable (excluding real estate taxes)	6,147		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 305,011	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 305,011	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 3,066,354	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,371,365	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,784,467	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,784,467	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	408,038	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) Dnr Rst Prop Gft Cash	5,144	15
16	Other (describe) Dnr Rst Gft Cash	647	16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 413,829	17
	B. Transfers (Itemize):		
18	Reserve Fund Assessment NC	(111,290)	18
19	Technology User Assessment NC	(20,652)	19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (131,942)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 3,066,354	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number GOOD SAMARITAN SOCIETY - MT CARROLL # 0007344 Report Period Beginning: 01/01/2009Ending: 12/31/2009**XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.****Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 4,203,957	1
2	Discounts and Allowances for all Levels	(1,183,283)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,020,674	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	532,768	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 532,768	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	12,281	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	154,237	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	16,190	19
20	Radiology and X-Ray	1,942	20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 184,650	23
D. Non-Operating Revenue			
24	Contributions	20,094	24
25	Interest and Other Investment Income***	194,772	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 214,866	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>NS & Med Supplies</u>	73,189	28
28a	<u>Sch Attached</u>	31,861	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 105,050	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,058,008	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	735,809	31
32	Health Care	1,768,411	32
33	General Administration	902,999	33
B. Capital Expense			
34	Ownership	196,231	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	39,992	36
D. Other Expenses (specify):			
37	<u>Lab and Radiology</u>	6,528	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,649,970	40
41	Income before Income Taxes (line 30 minus line 40)**	408,038	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 408,038	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number **GOOD SAMARITAN SOCIETY - MT CARROLL**

0007344

Report Period Beginning: **01/01/2009**

Ending:

12/31/2009

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,087	1,839	\$ 54,009	\$ 29.37	1
2	Assistant Director of Nursing					2
3	Registered Nurses	16,381	15,136	392,148	25.91	3
4	Licensed Practical Nurses	5,440	5,014	115,459	23.03	4
5	CNAs & Orderlies	64,740	59,041	702,878	11.90	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,072	1,834	27,175	14.82	9
10	Activity Assistants	5,269	4,848	45,905	9.47	10
11	Social Service Workers	2,045	1,826	31,032	16.99	11
12	Dietician					12
13	Food Service Supervisor	2,129	1,814	29,197	16.10	13
14	Head Cook	6,370	5,718	61,910	10.83	14
15	Cook Helpers/Assistants	10,855	9,834	98,823	10.05	15
16	Dishwashers					16
17	Maintenance Workers	4,975	4,542	57,820	12.73	17
18	Housekeepers	7,703	6,944	76,836	11.07	18
19	Laundry	5,409	4,992	50,729	10.16	19
20	Administrator	2,089	1,869	64,116	34.30	20
21	Assistant Administrator					21
22	Other Administrative	10,590	9,597	185,077	19.28	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,863	1,646	28,214	17.14	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	150,017	136,494	\$ 2,021,328 *	\$ 14.81	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	102	\$ 5,224	Ln 1 Col 3	35
36	Medical Director	16	2,400	Ln10 Col 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant		2,280	Ln10 Col 2	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	32	1,760	Ln 11 Col 4	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	150	\$ 11,664		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses			50
51	Licensed Practical Nurses			51
52	Certified Nurse Assistants/Aides			52
53	TOTAL (lines 50 - 52)		\$	53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			Ownership %	Amount	D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions				
Name	Function				Description	Amount	Description	Amount				
Jennifer Dunk	Administrator			Workers' Compensation Insurance	\$ 77,306	IDPH License Fee	\$					
vacation accrual				Unemployment Compensation Insurance	5,578	Advertising: Employee Recruitment						
				FICA Taxes	147,709	Health Care Worker Background Check						
				Employee Health Insurance	187,643	(Indicate # of checks performed)						
				Employee Meals		Dues Non Reim		1,212				
				Illinois Municipal Retirement Fund (IMRF)*		Public Relations		669				
				Pension	43,150	Dues Reimb		5,115				
				Taxable Gifts	100	Inter Reim		1,774				
				Admin and Consulting	2,402	Advertising		10,421				
				Work Comp pd direct	476	Shrd Employ		(5,946)				
				Res Dev FICA	(948)	Less: Public Relations Expense	(
						Non-allowable advertising		(10,798)				
						Yellow page advertising		(1,963)				
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)				\$ 69,601	TOTAL (agree to Schedule V, line 22, col.8)		\$	463,416	TOTAL (agree to Sch. V, line 20, col. 8)		\$	484
B. Administrative - Other			Amount	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**					
Description				Description	Line #	Amount	Description	Amount				
Admin/Accounting						Out-of-State Travel	\$ 532					
						In-State Travel	912					
						Seminar Expense						
						Out of state	(532)					
						Travel Reimb Marketing	(20)					
						Entertainment Expense	(
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				\$ 150,814	TOTAL		\$		TOTAL (agree to Sch. V, line 24, col. 8)		\$	892
C. Professional Services			Amount									
Vendor/Payee	Type			Description	Line #	Amount	Description	Amount				
National Campus Medicare												
National Campus Medicaid												
Contract Services Admin												
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)				\$ 3,133	TOTAL		\$					

* Attach copy of IMRF notifications

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).

(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13	
													Amount of Expense Amortized Per Year
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$	
2	Heating	01/02	1,738	10	174	174	174	174	174	174	172		
3	Heating	04/02	1,288	10	129	129	129	129	129	129	127		
4	Heating	01/01	219	10	22	22	22	22	21				
5	Plumbing	02/01	910	10	91	91	91	91	91				
6	Wallpaper	07/01	230	5	102	49							
7	Paint	08/01	390	5	102	49							
8	Air Condition	09/01	511	10	51	51	51	51	51	51			
9	Air Condition	10/01	1,841	10	184	184	184	184	184	184			
10	Air Condition	02/01	901	10	90	90	90	90	90	90			
11	Plumbing	04/01	87	10	9	9	9	9	9	9			
12	Plumbing	01/01	5,879	10	58	58	58	58	58	58			
13	Heating	05/01	152	10	15	15	15	15	15	15			
14	Plumbing	08/01	1,402	10	140	140	140	140	140	140			
15	Plumbing	01/03	1,787	10	179	179	179	179	179	179	179	179	
16													
17													
18													
19													
20	TOTALS		\$ 17,335		\$ 1,346	\$ 1,240	\$ 1,142	\$ 1,142	\$ 1,141	\$ 1,029	\$ 478	\$ 179	\$

Facility Name & ID Number GOOD SAMARITAN SOCIETY - MT CARROLL

0007344

Report Period Beginning: 01/01/2009 Ending: 12/31/2009

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? 3643
If YES, give association name and amount. Life Service Network
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 7.5 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 16,695 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES No NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 39,992
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? _____ If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ _____ Has any meal income been offset against related costs? Yes Indicate the amount. \$ 12,281
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? Yes
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 30%
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? _____
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? _____
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Larson Allen LLP
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? _____
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.